Youth and Drug Abuse

A Planner's Guide to Multi-Functional Treatment

ARF Addiction Research Foundation
Fondation de la recherche sur la toxicomanie

YOUTH AND DRUG ABUSE: A PLANNER'S GUIDE TO MULTI-FUNCTIONAL TREATMENT

PROJECT COMMITTEE:

Elsbeth Tupker (Co-ordinator)
Sharon Airhart
Gwen Carroll
Virginia Carver
Garth Martin
Alan Ogborne
Wayne Skinner

Editing by Minerva Communications: Judi Stevenson, Marg Yeo

Dear Colleague,

One of the greatest challenges facing Ontario's addictions treatment system is the development of services for young people who experience problems with alcohol and other drugs.

The fact that youth are under-serviced was highlighted in the report of the Advisory Committee on Drug Treatment, *Treating Alcohol and Drug Problems in Ontario: A Vision for the 90's*. Among the report's recommendations was the expansion of treatment services for young people across the continuum of care, from identification and assessment through a range of treatment options to aftercare.

The committee's report also stressed the importance of establishing multi-functional treatment programs. By providing a range of treatment services under one roof, such programs are key to meeting the diverse needs of young clients in a co-ordinated and cost-effective manner.

As an aid to developing these services, the Addiction Research Foundation is pleased to present *Youth and Drug Abuse: A Planner's Guide to Multi-functional Treatment*.

The guide is intended as a practical resource for local planners and service agencies, providing key information and a framework for the planning and development of community-based youth treatment services. As such, it will help meet the need, identified in Ontario's new Substance Abuse Strategy, to co-ordinate cost-effective treatment services at the local level.

It is our hope that you find this guide a valuable tool as we work together to develop programs capable of meeting the treatment needs of our province's young people.

Mark Taylor,
President and CEO
January 1994

Table of Contents

1. INTRODUCTION

It is widely accepted that young people with alcohol and drug problems are best helped by services that are specifically geared to youth. Such services provide programs that appropriately meet the developmental needs of pre-teens, adolescents and young adults. Whenever possible, parents and other family members are involved in the treatment process. These programs reach out to troubled youth in schools, in youth-serving agencies, and on the street, to identify those who need help and to involve them in specialized treatment services for their drug and alcohol problems.

In Ontario there is an urgent need for more youth addiction services. The issue that youth are under-served was raised by the Advisory Committee on Drug Treatment in ***Treating Alcohol and Drug Problems in Ontario: A Vision for the 90's*** and has widespread public support as indicated in the report, ***Caring for Each Other***. The need for services spans the full range of the continuum of care, including early identification, assessment, outpatient, day and residential treatment. In addition to service gaps, other shortcomings of the treatment service system for youth include:

- poor access to existing services;
- a lack of integration and co-ordination of services at both the client and agency level;
- failure to address the cost-effectiveness of treatment.

Shortages of services for children and youth are also addressed in ***Partners in Action: Ontario's Substance Abuse Strategy***. One of the strategy's goals is to foster more co-operation and better collaboration among ministries, agencies, community groups, providers, municipal governments and others so as to provide equal access to services for people with substance abuse problems.

Health recovery (treatment) access will be improved by addressing the following needs:

- a range of treatment services across the province;
- a shift to community-based outpatient care;
- services to detect and treat substance abuse in its early stages;
- a clear statement of responsibility for each ministry involved in residential care;
- special attention to key populations;
- co-ordination of local services;
- access to a wide range of services, regardless of where the person enters the system;
- research into cost-effective treatment.

Ontario's Substance Abuse Strategy will take action to:

- develop better ways to serve the needs of children and youth in co-operation with the Ministry of Community and Social Services;
- promote early identification screening, referral and case management in settings other than the formal treatment system, such as correctional and educational settings;
- emphasize the the pivotal role of community groups and organizations in planning services to meet local needs.

To address existing service deficits, the Advisory Committee on Drug Treatment recommends significant expansion of treatment services across the full continuum of care, with particular emphasis on the development of multi-functional treatment programs for youth up to age 25.

Multi-functional treatment refers to programs that offer more than one function of the continuum of care under one roof, under one administration, or under an inter-agency agreement to co-ordinate services.

Given the current economic climate, new resources will be limited. Service gaps and shortcomings may need to be addressed through a shift or expansion of existing services to increase the number of functions offered in a setting and/or through inter-agency collaboration agreements that co-ordinate access to multiple functions.

This guide has been prepared by the Addiction Research Foundation to help local planning groups develop multi-functional services for youth with substance abuse problems. Whether you represent a planning group, such as a district health council, local youth service coalition, public health unit, or community health centre, or are a program manager concerned with expanding existing services to address the alcohol and other drug problems of youth, you will find practical information in this guide to help you plan and develop new services.

The guide should be used as a resource as you proceed with the steps of the planning process, such as those outlined in ***Planning Ontario's Health Care Services in the 1990s: An Introduction to District Health Council Planning***, prepared by the Association of District Health Councils of Ontario. The guide provides you with specific information about treating youth with substance abuse problems to help you formulate the general ingredients of your plan, develop a model of what should exist, and to help you focus the inventory of existing services, the needs assessment and identification of service gaps and other problems.

The first section of the guide defines multi-functional treatment services and provides a rationale for planning multi-functional treatment.

Subsequent sections focus on the five phases of a comprehensive approach to alcohol and drug problems, as outlined in ***Treating Alcohol And Drug Problems in Ontario***:

- Identification,
- Detoxification,
- Assessment and Treatment Planning,
- Treatment and Rehabilitation,
- Continuing Care.

A final section deals with Case Mangement, a function that cuts across all phases.

For each phase the following are presented:

- **Service Objectives**;
- **Functions** that pertain to the phase;

- **Planning** issues such as inter-agency co-ordination, the selection of the appropriate setting for the service, and meeting the needs of special target groups;
- **Implementation** issues such as policies and procedures and staffing resources;
- **Case Examples** of existing programs that illustrate how multi-functional services can be implemented, including the name of a contact person for further consultation;
- **Resources** that are available to help you plan and implement services.

Program evaluation and quality management are beyond the scope of this guide; however, these functions should also be considered when planning and developing treatment services. The systematic gathering of verifiable information concerning the operations, results and cost-effectiveness of programs will require planning of standardized methods for gathering client information and for monitoring service delivery. Quality planning, quality control and quality improvement will involve the development of performance standards and related performance indicators for each of the service functions. References related to program evaluation and quality management are included under Resources in this section.

RESOURCES:

A practical step-by-step guide to the planning process is described in: Association Of District Health Councils of Ontario. (1991). ***Planning Ontario's Health Care Services in the 1990's: An Introduction to District Health Council Planning.***

The following three publications are helpful resources for program evaluation and quality management: Berwick, D.M., Godfrey, A.B., Roessner, J. (1990). ***Curing Health Care: New Strategies for Quality Improvement.*** San Francisco: Jossey-Bas.

Graham, K. et al. (1992). ***Directory Of Client Outcome Measures for Addiction Treatment Programs.*** Addiction Research Foundation.

Youth and Drugs: An Educational Package for Professionals. (1991). The Addiction Research Foundation. Unit 5 has a section on program evaluation.

Mammoliti, G. (1991). ***Caring for Each Other.*** Ministry Responsible for the Provincial Anti-Drug Strategy.

Martin, G. et al. (1990). ***Treating Alcohol and Drug Problems in Ontario: A Vision for the 90's.*** Ministry Responsible for the Provincial Anti-Drug Strategy.

Ministry of Health. (1993). ***Partners in Action: Ontario's Substance Abuse Strategy.***

2. MULTI-FUNCTIONAL TREATMENT

2. MULTI-FUNCTIONAL TREATMENT

Multi-functional treatment refers to the provision of two or more functions of the continuum of care under one roof or administration, or through inter-agency collaboration agreement.

The Advisory Committee on Drug Treatment has suggested that treatment provision for people with alcohol and drug problems can be usefully organized into phases and functions (see Figure 1).

"Multi-functional" may refer to a range of functions reflecting the different phases of treatment (Identification, Detoxification, Assessment and Treatment Planning, Treatment and Rehabilitation, and Continuing Care), or to varieties of functions within a particular phase. The specific combination of functions you may choose to offer in any one service location should be determined by weighing many factors, including the state of local and regional services and the characteristics of the population to be served.

Ideally, multi-functional treatment programs will offer at least:

- an identification function;
- a comprehensive assessment function;
- a range of treatment functions, typically including outpatient treatments, continuing care and some provision for residential treatment.

Multi-functional programs are advocated for the treatment of youth for three main reasons:

Administrative efficiency:

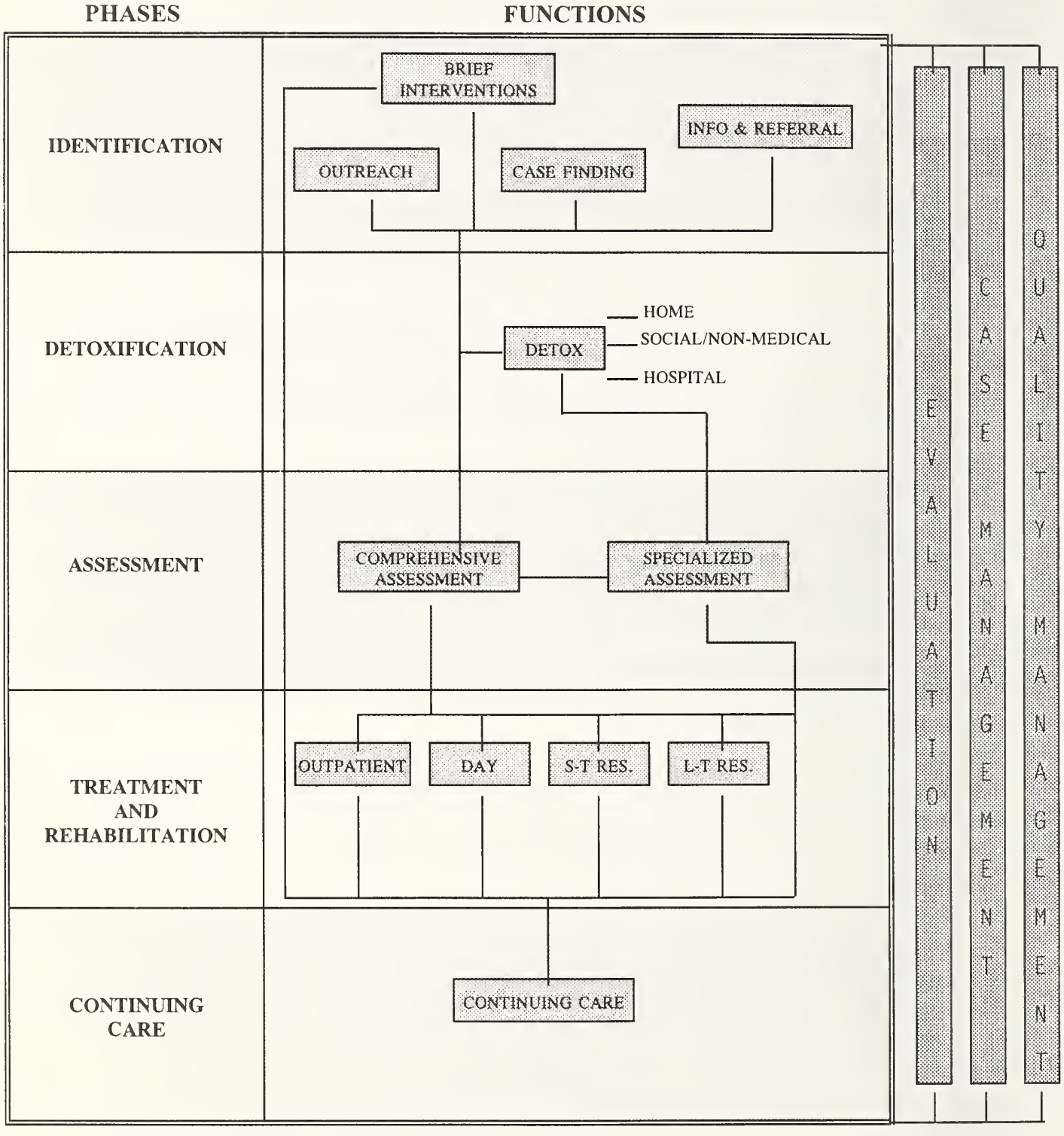
When single functions are provided by stand-alone agencies, administrative costs are at their highest in relation to the total cost of services. Multi-functional services are more likely to maximize the amount of service provided per treatment dollar.

Continuity of care:

It is generally agreed that deficits in the continuity of client care currently undermine the overall quality of treatment in the addictions treatment system. As individual young people progress through the phases of their treatment, they are frequently required to transfer from one service to another. This can be a very disruptive experience:

- they must establish new therapeutic relationships, which can be stressful;
- drop out rates are known to be higher at points of case transfer;
- the exchange of information may be impeded by issues of confidentiality and consent, hampering the new service provider.

Fig 1: Phases and Functions of a Comprehensive Response to Alcohol and Drug Problems.



NOTE: "S-t res." and "l-t res." refer to short- and long-term residential treatment.

Adapted from Martin, G. et al. (1990). ***Treating Alcohol and Drug Problems in Ontario: A Vision for the 90's.***

While most conscientious clinicians are sensitive to these potential disruptions and act to minimize their impact, continuity of care can be more easily maintained in multi-functional programs. Transitions from one function to another can be planned and executed with maximum sensitivity. For example, new therapists may be introduced gradually, or clients may move from one function to another without changing therapists. In addition, staff typically work as a team. The existence of both formal and informal lines of communication ensures easier exchange of information and greater collaboration among those involved in a multi-faceted treatment plan.

Appropriate use of treatment options:

Another advantage of multi-functional settings is the potential to use intensive and expensive treatment options more efficiently. For example, it is widely recognized that most clients do not require residential treatment, although we lack specific criteria to assess youth along this dimension. Practitioners who work with youth across the spectrum of treatment offered in a multi-functional program -- e.g., outpatient, day treatment and residential -- develop increased sophistication in their ability to determine which treatment option is best suited for their clients.

In multi-functional facilities, staff can more readily arrange shifts between types of treatment as clients' needs change. For example, a client in residential treatment might rapidly achieve enough stability to move to day treatment. Or, a client who starts treatment on an outpatient basis may require the added support of a protective residential setting.

In summary, multi-functional settings offer practitioners the flexibility to match treatment function to clients' evolving needs. They also promote the development of clinician expertise to facilitate the most efficient use of treatment resources. Finally, clients who are ambivalent about less intensive treatment options may be more willing to try them when they know that more intensive options are available if needed.

PLANNING MULTI-FUNCTIONAL TREATMENT:

Multi-functional treatment programs for youth that are located in one setting are the ideal model. ***Treating Alcohol and Drug Problems in Ontario*** recommends the development of multi-functional centres that offer residential treatment in three or four regions across the province. Given current fiscal restraints, however, it is unlikely that there will be much development of new centres in Ontario. Instead, such centres can be developed by adding needed functions to existing treatment facilities. This might be achieved by combining treatment components in different settings under one administration, or by linking several treatment functions offered under different administrations through inter-agency collaborative agreements.

The various functions of treatment for youth may be located within a variety of service systems. Organizations that should be considered as suitable for administering multi-functional youth treatment programs include youth and family service agencies, native organizations, general hospitals and community health centres, children's mental health centres, young offender and addiction-specific agencies.

A limited number of functions, such as those specific to the identification phase and continuing care and case management, may be provided by social agencies, public health agencies, medical practices, recreational programs, religious organizations, by employers within the workplace through EAPs and, most importantly for youth, in schools.

In planning a multi-functional centre, you will need to assess local and regional needs and identify the organizations that are most suitable for providing the administration.

The concept of the multi-functional centre should be interpreted in a flexible manner, reflecting the local needs that you have identified and promoting creative solutions to those needs. A multi-functional program can be:

- an elaborate new service, in which all of the needs of young drug users are addressed;
- the expansion of an existing youth service agency to include new functions of drug and alcohol treatment;
- the creative reorganization and/or integration of some existing services.

3. IDENTIFICATION

3. IDENTIFICATION

The Identification Phase consists of activities designed to identify youth whose use of alcohol and other drugs constitutes a potential, developing or established problem, and to deliver services that help such youth take constructive action in relation to these problems.

Identification is a relatively new but very important phase of the continuum of care that specifically addresses concerns in the health recovery field with early intervention and service accessibility.

SERVICE OBJECTIVES:

- to reach potential clients;
- to identify individuals who are at risk or already have problems;
- to intervene as early as possible;
- to prevent development of further problems;
- to refer to assessment and treatment, if necessary.

FUNCTIONS:

Outreach is taking proactive steps beyond the usual agency boundaries to identify and engage youth at risk for developing, or who already have, alcohol and drug problems. It consists of:

- going into settings where there is a concentration of youth who are at risk for developing, or who are already experiencing, problems related to drug and alcohol use.

- connecting with individuals or groups who are not likely to initiate a search for help with substance use-related problems and who are reluctant to approach addiction-specific services without assistance.

- a variety of activities appropriate to the setting and population.

For example, in the school system presentations, workshops, panel discussions or peer counselling programs are suitable.

With street youth, a much less structured and more indirect approach is used; for example, informal conversations with youth on the street or at drop-in centres or recreation activities are appropriate.

Case Finding is a process by which screening procedures are used to identify individuals with alcohol or drug problems.

The following methods are adapted to the setting in which they are used:

- informal discussions,
- structured screening interviews,
- questionnaires/instruments.

For example, an alcohol and other drug use screening instrument or questionnaire could be part of existing intake and assessment procedures of Children's Aid or Family Services or children's mental health agencies.

A youth worker at a drop-in centre or in a recreational setting will use informal conversation to introduce the topic of drug use and associated risks and problems.

Brief Interventions are very short-term counselling interventions, sometimes involving only a single session with groups, families or individuals, that provide information, advice, and strategies to help the youth change alcohol or drug use behavior.

They consist of early interventions such as:

- drug education,
- motivational counselling,
- self-control training,
- relapse prevention,
- crisis intervention,
- risk and harm reduction strategies, such as HIV prevention counselling, condom distribution and needle exchange.

Information and Referral provide clients with information about the types of services available for youth with alcohol and other drug problems, along with advice about how to access and use the services.

Usually, the referral process will involve direct assistance to help the youth get connected with a specific service.

PLANNING:

Inter-agency Co-ordination involves service integration between addiction-specific agencies and other generic agencies that serve youth with drug and alcohol problems. This integration is usually based on a reciprocal relationship in which each partner benefits by joining forces.

Co-ordination can be set up in different ways with partner agencies.

- **In a consultation model**, staff of an addiction-specific service assist staff in non-addiction settings to become skilled at identifying youth with drug and alcohol problems through training and back-up consultation.

- **In a service delivery model**, staff of the addiction-specific service contract with community-based agencies to provide identification functions on site for the clients of the partner agency.

Commitment on the part of addiction services of financial and staff resources will be necessary to ensure that appropriate programming and training are provided, and that procedures are consistently implemented. The contractual arrangements between partnering agencies should specify who bears the costs incurred for space rental, travel, telephone and program materials. Usually they are shared.

Typically, identification should occur in any **Setting** where youth are found:

- in schools, with the help of teachers, school nurses, guidance counsellors, psychology and social work staff, attendance counsellors, administrators;
- in youth agencies, including youth employment agencies, drop-in and storefront services, street workers' services and shelters;
- in family and children's services;
- in health clinics;
- in the corrections and young offender system;
- in community centres and other recreational programs.

A thorough inventory of existing identification services in your community will serve as a basis for setting priorities for the development of identification services in agencies that are not already performing these functions.

CASE EXAMPLE

The Early Intervention Program (EIP) of the Royal Ottawa Hospital illustrates these two methods of service co-ordination with the Carleton Board of Education.

- The program is involved with about 10 different schools per year to establish early identification and intervention programs for high-risk students.

- The EIP staff run psycho-educational groups which address a variety of issues, such as peer pressure, decision-making skills, communication and family issues, as well as a special program for parents of students who have been identified as high risk for developing substance use problems.

- The EIP has integrated a training component to its service delivery model. While delivering a service to its young clients, the EIP requires schools to provide staff time for a partnership in service delivery. EIP staff do brief presentations on early identification to all school staff, and more in-depth training for those individuals who will be more closely involved with the program. School staff involved in co-leading groups thus acquire the necessary practical skills and knowledge to run groups and provide identification.

- The duration of the intensive involvement of EIP with school staff is usually for two to three group cycles before the school staff can function autonomously. EIP staff then continue to be available in a consultative, supportive role. This process allows the EIP to move on to other schools while the school program continues to be delivered by staff.

For more information on early intervention in schools and the *Early Intervention Program Manual* contact: Lena Charette, Director, Early Intervention Program, # 4, 250B Greenbank Road, Nepean, ONT., K2H 8X4. Phone: (613) 596-6622.

A Community Needs Assessment should focus on identifying subgroups of the overall target population that are under-served.

Under-served youth are usually hard to reach and therefore require outreach services. They include:

- street youth,
- gay and lesbian youth,
- youths with physical disabilities,

- specific ethno-cultural groups,
- youth with alcohol- and drug-abusing families,
- youth living in high risk neighborhoods where drug use is prevalent,
- youth in conflict with the law,
- youth who have been physically or sexually abused,
- pregnant adolescent women.

Youth in these groups have special needs that require outreach, case finding and intervention approaches which can accommodate and be sensitive to their unique situations.

Agencies that are experienced in working with youth belonging to these special needs groups will be able to advise the planners of the addiction-specific service as to how identification and other activities can best be planned and tailored to the clients.

Families, usually parents, are often the first to become concerned about a young person's substance use. Reaching families will increase the likelihood that youth will get the help they need:

- brief interventions with the family can facilitate change even in cases where the youth is not willing to get help;

- education groups help parents deal constructively with family disruptions associated with their son's or daughter's substance abuse and help them to motivate the user to change his/her behavior.

Other concerned individuals, such as friends, coaches, ministers, family doctors, etc., are also able to identify youth needing substance abuse treatment:

- such concerned individuals often request advice and information that can be provided via a telephone consultation service.

CASE EXAMPLE

The **YMCA Substance Abuse Program (YSAP)** was planned and developed by The Coalition of Agencies Serving Downtown Youth in Toronto to provide addiction-specific services for street youth. YSAP offers assessment and treatment, and identification through outreach is a major and well-developed component. YSAP's goals for the identification phase are to identify youth on the streets of downtown Toronto with substance use problems, to engage these youth for assessment, referral and treatment, and to prevent or reduce harm related to high-risk behaviors through HIV and drug education.

YSAP has established partnerships with seven different agencies that consist of shelters, street youth outreach and drop-in services. The nature of the collaboration and the specific identification activities provided by YSAP vary according to flexible arrangements made with each partner agency.

To achieve their goals, YSAP staff may provide any one or a combination of the following functions at an agency site:

- training and education, and ongoing consultation with partner agency staff on identification of youth who are high risk for substance abuse problems;
- leading or co-leading drug education and basic life skills groups with partner agency staff;
- meeting with individuals who have been identified by partner agency staff to discuss problems, prevention strategies, and assessment procedures;
- regularly visiting a partner agency to identify potential YSAP clients through informal discussions with clients;
- organizing outings, recreation activities, and collaborating in the provision of a breakfast club for clients of partner agencies to engage in a non-threatening way those clients who may need treatment.

YSAP estimates that 800 clients are reached annually through these identification services and approximately 15-20% of clients follow through with YSAP assessment after the initial identification contact. Four staff devote approximately 10-30% of their time to these activities. Most of the costs of outreach are shared and absorbed by the operational budgets of the agencies involved, but $7,500 is specifically budgeted for the recreation and breakfast programs.

For further consultation on planning services for street youth, contact: Wendy Dolan, YMCA Substance Abuse Program, 137 Jarvis street, Toronto, Ont. M5C 2H6. Phone: (416) 867-9622.

IMPLEMENTATION:

There are several **Staffing Options** for outreach and case finding:

- functions can be distributed among frontline addiction agency staff who work with several partner agencies each, as part of their job description;
- a special outreach worker can be designated to do all of the outreach work;
- generic agencies may designate a particular staff member as the identification specialist who provides training and consultation to other agency staff. This "agency specialist" approach is one option. A consultative, or service delivery role is also possible.

There are advantages to having more than one staff member involved in outreach:

- matching outreach workers with specific community settings on the basis of gender, cultural sensitivity and experience is made possible,
- outreach team members can provide each other with support and backup.

Staffing Skills, especially flexibility, must be carefully considered:

- staff should be prepared to work flexibly and creatively in different settings, especially in non-structured environments where informal networking is very important;
- staff must have experience in relating effectively with youth and families with special needs;
- staff must believe that early identification and intervention with high-risk youth are crucial components of the continuum of care.

For identification to occur, frontline youth service providers need, at minimum, the knowledge and skills to screen for substance use and related problems and to make an appropriate referral.

Brief intervention skills are desirable but not essential, since these services could be offered by the addiction-specific service.

POLICIES and PROCEDURES must be in place in generic agencies to promote the identification of youth with substance use problems. These policies can be developed in consultation with addiction-specific agencies and should address issues such as:

- creating a non-threatening environment that is conducive to youth identifying substance abuse problems for themselves;
- routine screening of drug and alcohol use and related risks and problems, and referral when indicated, as part of the agency intake and assessment protocol;
- ensuring that disclosure of a substance abuse problem is met with appropriate responses that will help the client and connect him or her with needed services;
- informing the client of agency procedures and his/her rights with respect to confidentiality and disclosure of information.

It is important and useful to **involve the young clients themselves** in the development and implementation of outreach programs.

RESOURCES:

Models for operating outreach within the school system and with street youth are described in more detail in the Final Report of the Advisory Committee on Drug Treatment: Martin, G. et al. ***Treating Alcohol and Drug Problems in Ontario: A Vision for the 90's.*** Ministry Responsible for the Anti-drug Strategy.

Youth and Drugs: An Education Package for Professionals, (1991). The Addiction Research Foundation. It provides information and skill development in identification and early intervention with young people. Training is available in both self-study and trainer-led modes.

A similar package is available in French: ***Guide du formateur/programme de formation des intervenants de première ligne***, available through Albert Wener Consulting, 1916 Tupper Street, Montreal, PQ H3H 1N5.

For information and purchase of all the Addiction Research Foundation products listed in this guide, contact: Marketing Department, Addiction Research Foundation, 33 Russell Street, Toronto, Ontario M5S 2S1 (1-800-661-1111).

4. DETOXIFICATION

4. DETOXIFICATION

The detoxification phase consists of services to clients who are intoxicated or are in the process of withdrawing from alcohol and other drugs.

SERVICE OBJECTIVES:

- to assess and plan detoxification services;
- to provide a supportive and safe social and/or residential environment;
- to monitor the withdrawal process and respond to emerging needs;
- to provide information and assistance to the youth and support persons on dealing with withdrawal symptoms;
- to provide the necessary medical intervention required for safe withdrawal;
- to motivate the youth to change their drug and alcohol use and accept a referral to a treatment and/or other community service.

FUNCTIONS:

Assessment of the client's family and social circumstances, and physical and psychiatric condition, and planning for medical intervention (if needed), as well as appropriate social and residential supports is required. This includes:

- assessment of physical and mental health history and current status to identify conditions that require medical consultation or intervention;
- assessment of alcohol and drug use history, current drug use, and history of withdrawal symptoms to identify the need for medical withdrawal management;
- assessment of client preferences for managing withdrawal;
- assessment of family functioning and client's support network to identify appropriate support persons who can help the client through the withdrawal process;
- assessment of living environment to identify the extent to which it is safe, stable and drug-free;

- development of a minimally intrusive plan, in terms of setting and supervision, that is consistent with the youth's needs and preferences;
- identification of and connection of the youth with the available detoxification services;
- development of a post-detox treatment plan.

Social Support is the provision of information and the involvement of a person or persons to help the client through the withdrawal process. Social support includes:

- identifying and involving family and/or other support persons who can monitor the client's condition throughout the withdrawal process and provide any needed encouragement and assistance;
- providing information and guidelines (verbally or in the form of a handout) to help youths and their support persons through withdrawal. Contents might include:
  - information about what to expect, such as how long withdrawal normally lasts, and what some of the symptoms may be;
  - suggestions about how to deal with cravings, anxiety, irritability, sleep disturbances, restlessness and other symptoms of withdrawal;
  - phone numbers for back-up consultation with, for example, the closest detox centre, treatment program, or in case of emergency, the local hospital.

Residential Detoxification is the provision of 24-hour supervised care for withdrawal in a social or medical setting. This includes:

- residential services in a residential addictions treatment facility, a social detox centre or a hospital;
- alternative youth residential settings in the community, such as group homes, halfway houses, etc.

Medical Management of Withdrawal is the provision of medical consultation and interventions as needed. This includes:

- a comprehensive medical assessment;
- prescription of any needed medication(s);
- supervision of the use of prescribed medications;
- monitoring medical status;
- emergency medical care.

PLANNING:

There is no single **Detoxification Model** that is equally effective for all communities and for all clients. It will be necessary to plan and develop a variety of different models that address the needs of the local community, capitalize on local resources and meet the needs of youth. Options are:

Home detoxification in a supportive living environment such as the family home, a friend's home, halfway house, group home, etc.:

- monitoring and social support are provided by family, friends, volunteers, or group home worker to ensure the client's safe withdrawal;

- information, and advice to help the youth and support persons deal effectively with symptoms of withdrawal may be provided by a counsellor from a specialized addictions service who supervises the detoxification plan;

- a family doctor, a nurse, or other trained health professional will need to be involved if medication to aid withdrawal or other medical intervention is needed.

Outpatient or day detoxification offered by a specialized addiction treatment program, a detox centre, health clinic, or hospital:

- medication can be provided, as well as educational and therapeutic activities;

- monitoring is done by the family physician, and staff of the facility, supplemented by monitoring by the client's support system;

- usually the client attends the facility for regularly scheduled appointments, but in rural areas a mobile detoxification service, whereby staff travel to remote communities, can provide the needed care.

Residential detoxification in a social or medical setting that can provide residential care, such as:

- Non-medical community detox centres that are linked to a hospital and funded through the Ontario Ministry of Health.

- The existing detox centre model in Ontario is primarily an urban model that is less economically viable in rural and remote areas, nor is it well accessed by populations with special needs, such as adolescents and women.

- Detox centres take in **people 16 years and over**. While traditionally mandated to withdraw people from alcohol, most now also accept clients who are withdrawing from other drugs. Medical interventions are available when needed, usually through the sponsoring hospital.

- A substance abuse treatment program that has a residential facility is the preferred setting for youth who are to follow detoxification with short- or long-term residential treatment.

- Residential treatment programs for youth should have the capability to provide withdrawal management services to those who need it, and be sensitive to expectations concerning participation in the treatment program during the detoxification period.

- A local hospital may also provide residential withdrawal management when a concurrent medical condition or the severity of the withdrawal constitutes a need for inpatient care.

Inter-agency Collaboration and co-ordination with other local youth service providers, including volunteer and self-help organizations, will be necessary in planning detoxification services to access needed social and residential support services and enhance the efficiency of service delivery. For example:

- residential support can be arranged in collaboration with existing residential settings for youth, such as group homes, foster homes, halfway houses, and inpatient treatment programs;

- monitoring and support can be provided by trained practitioners who work with youth in a variety of social, medical and correctional services, as well as by trained volunteers, and informed friends and family members;

- training and ongoing consultation from specialized addiction service staff will be needed for those providing the support.

Planning for medically managed withdrawal and emergency medical services will involve collaboration with the local medical community. In most cases, medical interventions can be provided by a trained health care provider on an outpatient basis. Estimates indicate that only 2-5% of clients in withdrawal will require care in a medical facility. Options to consider are:

- family physician,
- community health centre,
- visiting public health nurse.

Options to consider for emergency care include:

- emergency visits by a physician or nurse,
- ambulance service for transportation to a hospital,
- hospital emergency departments.

Target Population: knowledge of characteristics of the youth population to be served, such as the specific drug use patterns, mental and physical health problems, family functioning and social stability, will provide some indication in the planning phase of the relative need for the different types of detox services.

- Most young drug users do not experience severe withdrawal symptoms because of the types of drugs they typically use (alcohol, cannabis, and cocaine) combined with a relatively short history of use and, therefore, may safely withdraw without medical intervention in a supportive home environment or on an outpatient or day basis.

- Locally prevalent drug use patterns among youth in the community to be served – such as gasoline and glue sniffing, opiate, benzodiazepine and barbiturate use – should be identified in planning medical detoxification management services, since users of these drugs may need medical services.

- Other indications for medically supervised detoxification are medical emergencies (such as threats of suicide, overdose, etc.), co-existing psychiatric or chronic, serious physical health problems, and a previous history of serious withdrawal problems.

- Youth who lack a stable, supportive and drug-free living environment are likely to have more difficulties becoming drug-free. This includes youth living in a family home where there is serious conflict or where the parents are unable to cope with the youth. These youth may need the support of a residential environment or alternative supportive living environments, such as a foster or group home or halfway house for detoxification.

- Communities with large numbers of homeless youth, or youth living in neighborhoods with a high concentration of drug use will need to plan for adequate residential and alternative supportive living capacity. Estimates indicate that up to 20% of detoxifying clients may need a residential setting.

IMPLEMENTATION:

Policies and Procedures appropriate for accommodating youth in residence should address the following factors, when considering the use of an existing detoxification centre or addiction-specific treatment programs, or hospitals designed to serve an adult population:

- the advisability of mixing youth with older clients;
- the availability of special programming for youth;
- whether staff are trained and comfortable working with young people;
- whether staff are familiar and comfortable handling withdrawal from different types of drugs that young people may use, in addition to alcohol.

Clients in withdrawal may have difficulty concentrating, staying awake, or sitting still for extended periods of time. Expectations about participation in an active treatment program during the first week may have to be modified to accommodate these effects.

Staffing Options will vary considerably, depending on whether medical intervention is required and whether home, outpatient or residential detoxification is chosen as the preferred model:

- Non-medical outpatient detoxification that is provided as part of a specialized addictions treatment program will not require additional staff resources. Withdrawal will be an integral part of the treatment process, which is usually managed by the primary counsellor.

- Programs providing residential care should ensure that there are at least two staff on each shift, in order to provide individual attention if required.

Staffing Skills for implementing detoxification will include training in:

- assessment,
- planning for appropriate social support and medical intervention (if indicated),
- intervention skills to help the young person deal with withdrawal symptoms.

RESOURCES:

Communities that do not have an adult detoxification centre and wish to develop one should consult the Ontario Ministry of Health ***Guidelines on the Planning, Organization and Operation of a Detoxification Unit***, (1979), as well as ***Detox in Ontario***, William L. Watt, Addiction Research Foundation, Toronto, (1988), or contact the Ministry of Health, Adult Community Mental Health Branch's Community Program Consultant for their area.

Planning Withdrawal Management Services for Small Urban Centres, Rural and Remote Areas of Ontario, (1993). Addiction Research Foundation, discusses a framework for detoxification service delivery alternatives and provides a structure for planning and implementation.

Alcohol Withdrawal Syndrome is a set of three videos providing step-by-step training in the assessment and management of alcohol withdrawal. It is available from the Addiction Research Foundation.

Youth & Drugs: An Educational Package for Professionals, (1991). Addiction Research Foundation, Unit 2 covers youth drug use patterns, drug effects and withdrawal symptoms; Unit 4 covers detoxification assessment and planning.

5. ASSESSMENT AND TREATMENT PLANNING

5. ASSESSMENT & TREATMENT PLANNING

The assessment phase consists of systematic procedures for the identification of a youth's major strengths and problem areas, culminating in a treatment plan and referral(s) for assistance.

SERVICE OBJECTIVES:

- to identify the nature and severity of substance abuse problems;
- to screen for other problems that may require additional specialized assessments (e.g., psychiatric or medical problems);
- to identify problems in general life functioning, such as family and peer relations, school and work, leisure, legal status, etc., and their relationship with drug use;
- to develop an individualized treatment plan based on the findings of the assessment;
- to match the client with and refer to the most appropriate treatment program.

FUNCTIONS:

Comprehensive Assessment is the process whereby the service provider seeks information about the client in order to select, develop, pursue and evaluate methods of intervention. It consists of:

- one-to-one, informal interviews in order to establish rapport, and to explore issues from the client's perspective;
- structured interviews, self-completion questionnaires, and objective assessment instruments to ensure that the assessment is comprehensive and objective;
- gathering information from other sources, such as family assessments, and reports from other service providers;
- establishing a database to serve as a baseline for evaluating individual client treatment outcomes, as well as overall program objectives.
- defining the specific problems, strengths and corresponding treatment objectives that are to be pursued;

Treatment Planning is the interpretation of assessment information and the creative use of local and other resources to ensure that clients are provided with the best, most relevant and cost-effective forms of assistance. It consists of:

- providing clients with feedback and involving them in the planning process;
- outlining the methods and service resources to be used to address problems;
- monitoring the youth's progress toward treatment objectives and revising the original treatment plans if progress is not satisfactory.

Referral facilitates the youth's access to specialized services, such as medical or psychological assessment and treatment, supportive accommodation, vocational rehabilitation and addictions treatment programs, as indicated in the treatment plan. This includes:

- familiarity with the services that exist in the community for youth and families;
- orienting the youth to the needed service(s) and involving the youth in choosing the service(s) that will be used;
- facilitating the referral process by providing the necessary information, including the assessment report (with the client's consent) to the referral.

Data Collection at intake and during the assessment documentation of demographic, descriptive, and background information on clients is an important function that:

- yields baseline data necessary for tracking a client's progress;
- provides program information that can be used for program evaluation and quality management;
- contributes to a client and treatment information system that is useful for treatment system planning.

Currently the Ministry of Health, in conjunction with ARF, is developing a Client-Based Information System that will include instruments and procedures for the collection and analysis of four types of client data:

- demographic, descriptive and background information on clients referred/admitted to programs;
- information on types and amount of services provided;
- information on discharge circumstances and profiles of clients served;
- follow-up information collected on a sample of clients on substance use/abuse, including client behavioral and lifestyle characteristics at several points following treatment.

PLANNING:

Assessment Protocol consists of the procedures, methods, forms and instruments used by the practitioner to collect information from the youth and from other sources, to record it in a co-ordinated and consistent fashion and to assist in determining problem severity and appropriate treatment plans. When planning the assessment protocol, the following should be considered:

- Assessments with youth usually combine a variety of information gathering procedures, such as highly structured questionnaires, standardized tests, guided interviews and informal discussions.
- Procedures may include therapist- or self-administered questionnaires or tests, as well as computerized questionnaires.
- The assessment protocol serves as a guide and should be sufficiently flexible to adapt methods and procedures to the needs and circumstances presented by individual clients.
- There are several comprehensive assessment instruments specifically designed for adolescents from which a newly developing service may choose. On the other hand, services may wish to develop their own assessment format and incorporate parts of instruments that they already use.

- There are three advantages to youth addiction services using a common assessment protocol:

  - It ensures that youth's needs will be assessed in a consistent, systematic manner, regardless of the point of entry into the treatment system.

  - It contributes to a consistent treatment planning approach.

  - In conjunction with the Client-Based Information System, this approach yields a comprehensive database of client and treatment information that could be useful for treatment system planning purposes.

Assessment services for young adolescents (under 16 years of age) are not well-developed in Ontario. Most are not mandated to assess youth under 16.

The Ministry of Health intends to address this problem by broadening the mandates of assessment and referral services and youth treatment services to include young adolescents.

As well, the Ministry of Community and Social Services intends to broaden the mandate of the children's mental health system to assess and treat young adolescents with substance abuse problems.

The Ministry of Health also plans to develop and disseminate an assessment protocol for young adolescents, and staff training for those who perform such assessments.

Usually, assessments are conducted on an outpatient basis, but the possibility of providing residential supportive care to youth who are too unstable to attend on an outpatient basis and youth who live far away should be considered.

Significant others, such as family, guardian, or partner should be involved in the assessment process, provided the client agrees. Usually, separate sessions are reserved for family assessments or the involvement of significant others.

Verbal and/or written reports from key practitioners who have provided services to the client are also helpful for assessment and treatment planning.

Inter-Agency Collaboration: In Ontario, many communities have assessment and referral centres that provide services to youth. Co-ordinating intake and assessment functions with existing assessment and referral centres is advisable to avoid duplication of service. Some service co-ordination options are:

- A/R centres will provide assessments for youth who are identified in a variety of settings, either in the local A/R centre or in the setting where they are identified.

- Youth who present at the local A/R centre are screened and referred to an appropriate youth-specific addictions treatment service for comprehensive assessment.

Co-ordination with A/R centres should include:
- agreement about the assessment instruments to be used;
- provision for the exchange of information between the A/R centre and the youth addiction service;
- decision about who will be responsible for case management.

Provisions for access to specialized assessments such as medical, psychological and psychiatric assessments will need to be set up in collaboration with local resources.

IMPLEMENTATION:

Policies and Procedures for implementing the assessment functions should address the following issues:

- Engaging the youth through initial one-to-one, informal interviews to establish rapport, and to explore issues from their perspective.
- Orienting the youth to the assessment process and procedures including:
  - why assessments are being done;
  - how long they will take;
  - what issues will be considered;
  - what special 'tests' will be given;
  - how confidentiality will be ensured.
- Duration of the assessment process should allow for some flexibility. It will usually span several sessions, given the comprehensiveness and nature of the topics to be covered. The client's communication style, attention span, level of motivation and co-operation with the process all contribute to the time it will take.

A comprehensive assessment should address the following:
- the presenting problem, or reason for assessment;
- a detailed history of alcohol and drug use and treatment history;
- medical status (self-reported or, preferably, as determined by a physician);
- current social functioning, including accommodation, marital, educational and employment status;
- family functioning, including relations with parents, siblings and other significant family members, usually explored in a family assessment;

- social support networks, peer relations, including involvement with drug and alcohol users;
- current leisure activity profile;
- current legal problems;
- sexual orientation;
- history of sexual, emotional and physical abuse;
- propensity for violence;
- mental health status (especially signs of depression or psychosis and history of suicide attempts);
- readiness for change.

CASE EXAMPLE

The Metro Addiction Assessment Referral Service in Toronto was developed recently in a context of several existing youth addiction treatment programs throughout the city that already provided comprehensive assessment, treatment planning and referral.

- MAARS consulted during their planning phase with these youth treatment agencies to develop a response to youth who seek their A/R services that would not duplicate the assessments that youth receive in the treatment programs to which they are referred.

- Instead of a comprehensive assessment, a brief screening, either over the phone or in person, is done with the youth to determine whether a referral to a local youth treatment program is appropriate and to identify the most suitable program.

- A client profile report is sent to the referral destination and follow-up contacts are made with the client by the MAARS worker at one week and five weeks after initial contact.

- About 50% of young clients presenting to MAARS are referred on the basis of a brief screening.

- When clients' treatment needs are unclear during brief screenings, they receive comprehensive assessment and case management from MAARS.

For more information on MAARS's brief screening procedures and comprehensive assessments with youth, contact: Larry Jelinek at Metro Addiction Referral Service, 124 Merton Street, 5th floor, Toronto, ONT. M4S 2Z2. Phone: (416) 481-1446.

CASE EXAMPLE

The Addiction Assessment Services of Ottawa-Carleton (AAS) provide assessments, referral and case management for people of all ages. They have developed a special service delivery package for youth and their families that emphasizes access within a short period of time and, when appropriate, service provision on-site in the setting with which the youth is affiliated or from which the youth has been referred.

- On-site collaboration with schools of the Ottawa and Carleton boards of education and a variety of other youth and family service settings appears to decrease the difficulties of accessing help, increases the likelihood of follow-through and allows for creative sharing of case management activities between AAS and their community partners.

- A formal agreement between AAS and the David Smith Centre, a day treatment program for youth age 14-18, has AAS providing on-site assessment services (approximately 1.5 days per week) to clients who present at the David Smith Centre. If the Centre is the recommended treatment program, an informal orientation to the program is conducted, which helps alleviate many of the misconceptions and anxieties surrounding the decision to enter treatment. If the youth agrees to engage in this treatment, then David Smith Centre staff assume case management responsibilities.

For more information about collaboration with Assessment Services, contact: Stephen Kennedy, Director, Addiction Assessment Services of Ottawa-Carleton, Sandy Hill Health Centre, 24 Selkirk Street, Vanier, ONT. K1L 6N2. Phone: (613) 741-8941.

Treatment Planning is as much an art as a scientifically informed undertaking, given how little we know about the effectiveness of treatments for alcohol and drug abuse with youth. However, on the basis of reviews of empirical studies, the pooled experiences of clinicians in the addictions field, and "common sense" notions of effective treatment, a number of principles of good treatment planning are proposed. They are tentative, and await the results of further research and experience.

- Where appropriate, and only with the consent of the client, family members and/or significant others should be consulted concerning the most appropriate treatment plan.

- Priority should be given to using the least intrusive interventions (e.g., outpatient treatment) in order to minimize disruptions to the client's positive domestic, vocational and social arrangements.

- The treatment plan should seek to maximize the client's strengths and support systems to work towards identified goals, while reducing identified problems.

- The negotiated treatment plan should acknowledge and reinforce the client's personal responsibility for his/her health-related behaviors.

- Arrangements should be made to ensure continuity of care through the provision of case management.

If the treatment plan involves referral, preference should be given to community agencies that provide individualized planning, monitoring and re-evaluation.

- To address the special needs of young women, agencies that provide specific programming for women should be considered.

- The treatment plan should be comprehensive and holistic, and take account of all identified contributing factors.

- Desired outcomes should be clearly specified using language which makes sense to the young client.

- Clear behavioral criteria for monitoring progress should be developed with the participation of the client.

Treatment Options are many, and clients' needs differ. Some principles and suggestions for matching young substance users with the best possible treatment for them are as follows:

- Clients should be involved in the selection of treatment methods.

- Clients who report that they intend to do physical harm to themselves or others should be referred to a qualified physician or psychiatrist.

- Clients with more severe problems may require more intensive (but not necessarily residential) treatment.

- Clients seem to make more progress when matched with treatments that are consistent with their cognitive styles (e.g., those with a strong need for direction/structure tend to do better in a highly structured program, etc.)

- Alcoholics Anonymous and Narcotics Anonymous are extremely helpful to some people, either as treatment options or as adjuncts to treatment. However, they are often unappealing to adolescents, who generally do not see themselves as "alcoholics" or "drug addicts."

- The role of beliefs is important with respect to AA and, in fact, to all treatment modes: if the client believes the treatment will work, it has a greater chance of doing so.

- Methods that link clients with ongoing community resources appear to be most promising.

In **Staffing** an assessment service for youth, there are three main considerations:

- Services that provide assessments as well as other functions, such as case management and treatment, should consider the advantages of the same counsellor delivering these functions. Continuity of care, from both client and service perspectives, will be enhanced.

- Assessments with young people require special skills and sensitivities. Adolescence is often a time of fiercely felt but shaky independence. Teens don't usually respond well to pressure from adults. They need to feel that they can come to their own decisions but may appreciate a counsellor's patient, non-judgmental assistance.

- Effective treatment planning and referral requires an extensive knowledge of the service network for helping youth and families and of how to access them on behalf of the client.

RESOURCES:

A more detailed presentation of youth-specific assessment instruments and of the assessment process and treatment planning issues can be found in ***Youth and Drugs: An Educational Package for Professionals***, Unit 4. (1991). Addiction Research Foundation.

Instruments that are relevant to the assessment of youth were developed for the ***Ontario Drug and Alcohol Treatment Outcome Study***, (ODATOS) available from Dr. Alan Ogborne, Addiction Research Foundation, The Gordon J. Mogenson Building, 100 Collip Circle, Suite 200, U.W.O. Research Park, London, Ontario N6G 4X8.

A comprehensive listing of the treatment services in Ontario is provided by The Drug and Alcohol Registry of Treatment (DART), ***Directory of Alcohol and Drug Treatment Resources in Ontario***. (1993) Addiction Research Foundation. DART will assist professionals who are looking for an appropriate treatment service for youth (1-800-565-8603).

6. TREATMENT AND REHABILITATION

6. TREATMENT AND REHABILITATION

In the treatment or rehabilitation phase, interventions are employed to alleviate problems and to improve or restore the youth's health and social functioning.

SERVICE OBJECTIVES:

- to help the client understand the pattern of his/her drug use, its triggers and consequences, and its risks to health and well-being;
- to motivate the client to change his/her alcohol and/or drug use and other risk-related behaviors;
- to help the client set appropriate and realistic short-term and long-term drug use goals;
- to help the client set goals for improvement in problematic life areas, such as health, peer and family relations, education, employment, leisure, etc.;
- to help the client build skills, plan and implement strategies and develop social supports that enable him/her to achieve these goals;
- to help the client maintain, in his/her everyday life in the community, the skills, strategies, and supports that have been developed in treatment.

FUNCTIONS:

Treatment may be described from several perspectives, including intensity and structure of the delivery (e.g., outpatient, day/evening, residential), the modality of delivery (e.g., individual, group or family), the treatment content (e.g., skill training, leisure counselling), and the theoretical practice models (e.g., cognitive/behavioral approach, disease model).

Treatments vary according to these dimensions and, therefore, no one perspective adequately describes the specific treatment functions provided.

It is widely believed that matching clients with the appropriate intensity/structure, content, theoretical practice model and treatment modality increases the likelihood of positive outcomes.

Intensity & Structure of treatment depends on the particular needs of the young client. When deciding on the treatment option to pursue, the following options should be considered:

OUTPATIENT TREATMENT is treatment provided on a non-residential basis, usually in regularly scheduled sessions, as needed: weekly, daily, monthly, etc.

It is the least intensive and lowest structured form of treatment that offers the greatest variability with respect to duration, as well as treatment content and modality.

Contrary to popular perception, outpatient treatment is a commonly used and effective treatment option for youth. The literature indicates that:

- 80% of young people receive outpatient treatment;
- more intensive and structured treatments (such as day or residential treatments) are no more effective with this population than outpatient treatment.

Given the absence of clear empirical evidence to guide the matching of treatment to client characteristics, it may be wise to consider outpatient treatment as the treatment of choice for young people, unless there are clear indications that a more structured and intensive program is required. (Indicators that point to the need for day or residential treatment are discussed in upcoming sections).

Special advantages of outpatient treatment are:

- it maintains and builds on the youth's existing adaptive community involvements;
- personal strengths and practical coping strategies developed in treatment are implemented in everyday community living;
- it is flexible and adapts content, modality, structure, duration and intensity to the individual needs of the client;
- it is cost effective.

DAY/EVENING TREATMENT is a more intensive and structured variation on outpatient treatment. It is typically provided five days a week, for three-seven hours a day, over a period of variable duration.

Day/evening treatment is a popular alternative for treating youth, because it combines the features found to be effective with young people in residential programs (intensity and structure) with several equally desirable features of outpatient programs (flexibility of content and duration, plus

a focus on community integration).

Special advantages of day/evening treatment are:

- it uses primarily a group treatment modality in combination with individual and family treatments, according to client needs;
- a broad spectrum of needs are addressed by program content focusing on a variety of life functioning areas that may be offered flexibly, depending on an individual client's needs;
- it has sufficient variability to accommodate client needs with respect to frequency of contact (daily to as infrequent as twice a week), length of contact (a couple of hours to all day) and duration of treatment;
- it can provide temporary "time out" in a drug-free, safe and supportive therapeutic setting;
- it is a structured program with explicit expectations concerning frequency and duration of program attendance and participation.

RESIDENTIAL TREATMENT may be short-term treatment provided for an intensive structured period of time while the client resides in-house, typically less than 40 days, or long-term treatment and/or rehabilitation services provided for a period of time, typically longer than 40 days.

A small percentage of youth need to be removed from their environment and provided with a supportive living setting in order to benefit from treatment. Residential treatment offers such an environment, as well as a highly structured and intensive treatment program.

Residential treatment can have all the components of day treatment, with the added advantage of 24-hour supervision of clients.

Residential treatment models are:

- institutionally-based residential treatment in medical programs administrated and operated by, and usually in, hospitals. These programs are OHIP-insured. Several hospitals across the province accept youth 16 years and older into their programs, but treatment in these facilities is not necessarily youth-specific;
- long-term programs, which may include recovery homes, halfway houses, three-quarter-way houses and therapeutic communities;
- the use of existing residential services in conjunction with day treatment, as an

alternative, cost-effective approach to providing short-term residential treatment. Youth who are in a residential setting, such as open custody, a children's mental health facility or a group home could attend day/evening treatment while they continue to benefit from 24-hour supervision and a therapeutic environment.

Treatment Modalities such as individual, group, family and couple treatment have all been used effectively in the treatment of young drug users. They are often used in combination with each other.

INDIVIDUAL treatment entails regular counselling sessions with a therapist or counsellor. It has the advantage of flexibility, so that the content, frequency and duration of treatment sessions can be tailored to the unique needs of the client.

GROUP treatment is a cost-effective modality for outpatient treatment and is the treatment of choice in day and residential programs. Group treatment, while less flexible, has the following advantages:

- providing social support;
- appealing to adolescents who are more responsive to peer influence than to adult direction;
- providing an excellent setting for social skills training, leisure counselling, problem-solving and social support development.

In planning group treatment, consideration should be given to homogeneity of composition in terms of age, level of drug use involvement and special needs:

- The existence of separate groups for adolescents (under 18) and young adults (18-25) promotes cohesion and mutual support around age-related developmental issues.
- Group membership on the basis of level of drug use involvement is usually a good idea, since early stage users may be negatively influenced by heavy users in the same group. An appropriate division would separate those in the early stages of use from heavy users.
- Special needs groups may also be considered to address the common needs of certain clients, e.g., young women, survivors of incest or sexual abuse, those who are HIV-positive, street youth, gay and lesbian youth, etc.

Groups may be "open" (i.e., clients new to the program join an ongoing group) or "closed." Closed groups have the advantage of group cohesion, while open groups have the advantage that

more experienced group members can model therapeutic progress for newer members. An added advantage to open groups is that group size can be maintained despite client drop out.

FAMILY TREATMENT considers the family system, rather than the individual, as the unit of treatment. It is appropriate when family members recognize the need to deal with the complex issues surrounding a youth's drug use as a family.

The overall goal of family involvement in treatment is to identify and draw out the possibilities for positive change in the client and in the client's family.

Understanding the client's family context, and knowing when and how to draw on family and other social support, as well as identifying blockages to positive change that exist there, is a potent yet under-used way to advance the therapeutic process.

There is evidence that young people who lack family and parental support do worse in treatment than those who have it, and therefore family involvement in the treatment of youth may:

- help the young client resolve problems relating to substance use;
- reduce the risk of drop out and encourage completion of treatment;
- enhance treatment effectiveness.

Treatment can involve families in several ways:

- parents' groups in which parents meet together to share concerns and provide mutual support;
- family meetings which bring family members together, usually including the young drug user, to talk about specific concerns with the facilitation of a professional;
- family consultations, either over the phone or in person, which give information, support and guidance to concerned family members.

Treatment Contents should be practical and address the young client's ability to function in various life areas. The needs of the target population and the availability of other service resources in the community will determine which components to include in the program and which to access in the community through collaboration and partnerships.

- The **vocational** component addresses reintegration into the work or education environment;

- The **leisure** component addresses constructive use of free time. Most day and residential programs offer some recreational activities, such as games, sports or outings as part of a leisure program;

- The **health** components focus on how to develop a healthy lifestyle. They may address exercise, nutrition, birth control, STD and HIV prevention, etc.;

- The **social and peer relations** component focuses on developing a supportive social network. Social skill or assertiveness training may be part of this component;

- The **family relations** component addresses the development of a supportive family system. Treatment programs may involve family members directly through family education sessions or family therapy;

- The **stress management** component addresses adaptive methods for dealing with life stressors;

- **Special needs** of the target group may be addressed by additional components, such as literacy training, sexual abuse and family violence counselling, etc.

Theoretical Models of Practice have originated around different practice experiences and theoretical frameworks. The disease model, the 12 steps, the Minnesota model, the behavioral, the systems and the therapeutic community approaches all refer to models of practice that frame addictions treatment. When planning the theoretical model of practice with youth, the following should be considered:

- youth programs should employ models of practice that are developmentally appropriate for pre-adolescents, adolescents, and young adults and their families;

- in any given community, alternative approaches should be available to youth so that they will be able to find a model that is most appealing to them and fits with how they themselves view their substance use;

- programs for youth need not adhere to one specific theoretical model, but may employ elements from several theoretical orientations that are particularly effective in helping youth to change.

PLANNING:

Accessibility to the full range of the continuum of care for youth no matter where they live should be such that the particular treatment function a youth receives is determined by need, not availability. Planning issues to consider are:

- to justify the considerable capital investments and operational expenses associated with residential treatment, such programs should serve a larger geographical area and provide several phases of the continuum of care (assessment, treatment and continuing care), as well as other treatment functions;

- outpatient and day treatments must be within easy travel distance for the community they intend to serve;

- in rural or remote communities where access to a central location is difficult, it may be desirable to set up a mobile outpatient treatment service with a counsellor travelling to several communities to meet with youth at a set place and time;

- outpatient programs should consider providing their services in more than one location in order to be accessible to youth in areas that are under-served and/or where there are large concentrations of youth needing treatment;

- outpatient and day programs have to offer flexible hours of service to allow young clients and families to attend after or before school and/or work.

Co-ordination of Treatment: the different phases and treatment functions should be well co-ordinated and integrated at a client level, with respect to accessibility and continuity of care, so that clients can move smoothly and rapidly from assessment to treatment and continuing care and transfer from one treatment function to another when necessary. Two models of co-ordination are:

MULTI-FUNCTIONAL CENTRES are addiction-specific agencies that have the capacity to provide two or more phases and multiple treatment functions. They typically provide residential treatment for youth in a region, and assessments, as well as outpatient and day programs to local youth. The advantages of a multi-functional centre are:

- increased capability to respond to a variety of client needs;
- flexibility to match treatment functions to the client's evolving needs;
- minimal disruption for the client when changing from one level of treatment to another;
- easier co-ordination of case management;

- easier exchange of information;
- more efficient use of intensive and expensive treatment functions;
- administrative efficiency.

INTER-AGENCY COLLABORATION to integrate and co-ordinate existing services in a community and/or region and fill any service gaps is an alternative and less costly way to develop a multi-functional treatment capacity for a specific community.

Collaboration can be between addiction-specific agencies, such as A/R services and residential and outpatient programs and can also broaden the base of addiction service delivery to youth by involving various generic and non-addiction-specific agencies of the youth services network.

- Youth-serving agencies, such as C.A.S., street outreach services, family service agencies, children's mental health centres, etc., can deliver outpatient treatment to youth, in partnership with an addiction-specific agency by sharing staff and other resources.

- Local residential settings, such as a children's mental health residence, a young offenders' residence or a more generic halfway house could provide the necessary residential support to enable youth in these settings to participate in an addiction-specific outpatient or day treatment program.

- A residential setting such as a group home or halfway house will make beds available to youth in day treatment who need the structure of a residential setting.

Collaborative arrangements should address the following issues:

- quick, preferred access for transferred clients;
- exchange of information;
- case management and case sharing, whereby two services provide different functions of the same treatment plan.

CASE EXAMPLE

The Youth and Family Clinic at the Addiction Research Foundation in Toronto offers a variety of treatment functions in a co-ordinated and integrated manner that is determined by client need. The Clinic's functions include assessments, outpatient treatment, day/residential treatment in a 28-day Young Drug Users Program (YDUP), continuing care, and case management.

Efficient use of resources:

- The residential component of YDUP is provided by a 24-bed Residential Supportive Care Unit of ARF's Clinical Research and Treatment Institute.
- Ten beds are reserved for youth, while clients from other programs in the Institute are also housed there.
- The sharing of the residential facility and staff among a number of programs reduces costs.

Matching treatment functions to clients' evolving needs:

- Ongoing assessment of client need(s) may necessitate changes in the treatment plan, which can be readily arranged.
  For example, if there is a change in the living environment of a day client in YDUP that puts her at risk for drug use, she may continue with the program on a residential basis until the problem is resolved.
  Or, a client in YDUP who has violated a rule that has a discharge contingency may continue to receive counselling with his outpatient counsellor.

Minimal disruption to the client:

- Continuity of counsellor is maintained when possible as the client moves from assessment to outpatient treatment and continuing care.
- When a change of counsellors is necessary, as in the case of outpatients moving to YDUP, the original counsellor will provide supportive counselling during the transition phase and maintain contact throughout YDUP as the case manager.

CASE EXAMPLE continued

- After YDUP, the client may choose to go back to the original outpatient counsellor or continue with a YDUP therapist for continuing care.

Ease of exchange of information:

- The outpatient counsellor orients the multi-disciplinary YDUP staff to the client, the assessment findings and treatment plan.
- Barriers such as confidentiality and delays in transmitting information are non-existent as long as the information is contained within the boundaries of the Clinic.

Administrative efficiency:

- Duplication of administrative functions, such as client registration and client information management, are avoided and administrative supports such as reception are shared.

The Clinic also collaborates with a variety of other addiction services and non-addiction youth services to co-ordinate their clients' treatment needs with the Clinic's services.

A local street outreach service that provides identification, assessment and outpatient counselling with street youth may refer clients who need a more intensive treatment directly to YDUP for quick access. The outreach counsellor stays involved by visiting the client and attending case conferences to maintain continuity of care.

Assessment and referral services all over the province also refer directly to YDUP, with the understanding that A/R centres will arrange continuing care for out-of-town clients.

For more information about multi-functional treatment at the Youth and Family Clinic, contact: Shelly Pearlman, Youth and Family Clinic, Addiction Research Foundation, 33 Russell Street, Toronto, ONT. M5S 2S1. Phone: (416) 595-6032.

Target Populations: the community needs assessment should attempt to assess the needs of the target population, with respect to the level of intensity and program content of the treatment, in order to plan the capacities of the different treatment functions.

Population characteristics that indicate a need for day treatment are:

- regular and frequent substance abuse;
- absence of structure, stability and support around daily activities;
- multiple problems in various life areas;

- presence of high-risk situations for substance use on a frequent basis;
- failure to benefit from outpatient treatment.

Additional indicators for residential treatment are youth who have:

- signs of severe dependence;
- a pattern of use so compulsive, or so ingrained in daily activities, that getting control of drug use seems improbable;
- the absence of social and emotional supports for change in the youth's normal social and/or family environment;
- the absence of a supportive drug-free living environment.

A lack of housing is frequently considered to indicate a need for residential treatment:

- Special housing needs are very common with young drug users, but they should be considered separately from the need for residential treatment.
- Transitional and long-term independent or supported housing that youth in treatment can access should be addressed in collaboration with housing resources in the community.

In planning residential treatment, consideration should be given to:

- the appropriateness of single-sex versus co-ed accommodation;
- the special needs of gay and lesbian youth;
- the special needs of HIV-positive youth;
- the special needs of survivors of incest and sexual abuse;
- the special needs of ethnic minority youth.

IMPLEMENTATION:

Policies and Procedures concerning the following treatment issues should be in place:

- maintaining a safe and drug-free therapeutic environment;

- expectations concerning client participation in treatment and behavior in the program, with clearly formulated contingencies for failure to meet expectations;

- discharge contingencies for failure to meet drug use expectations, which are to be used judiciously, keeping in mind that the objective of treatment is the development of coping skills, a process that will undoubtedly entail failures as well as successes;

- health promotion and harm reduction strategies, which should be implemented with every client where risk is identified (e.g., HIV prevention, needle exchange, etc.).

Staffing: the necessary qualifications and skills of staff who provide treatment for youth are varied. The general skills all staff will need are:

- the ability to relate effectively to young people;
- basic counselling skills;
- an awareness of addictions.

Depending on the modalities and treatment content offered by the program, staff with specialized skills will need to be employed (i.e., family therapist, group counsellor, vocational counsellor, recreation therapist, health counsellor, etc.).

Treatment staff usually also carry out functions of other phases of the continuum of care, such as identification, assessments, case management and continuing care. It is desirable to maintain therapist continuity for clients whenever possible, as they move through the different phases.

RESOURCES:

Planning guidelines, such as those from the Ministry of Community and Social Services (MCSS) and the Community Mental Health Services Program (CMHSP), provide recommendations regarding staffing levels and occupancy rates.

More details regarding treatment procedures can be found in Unit 5 (Treatment) of ***Youth and Drugs: An Educational Package for Professionals***, (1991) Addiction Research Foundation.

The Ontario Association Of Children's Mental Health Centres has published ***Accreditation Program***, (1989), which contains standards regarding program, staffing and management.

McCrimmon, M., Tschakovsky K., (1992) ***The H.I.V Positive Client: A Guide for Addictions Treatment Professionals***. Addiction Research Foundation.

7. CONTINUING CARE

7. CONTINUING CARE

Continuing care refers to resources or services for the provision of continuing support, encouragement and additional counselling to a client after a treatment program or plan is completed.

SERVICE OBJECTIVES:

The overall objective of continuing care is to maintain and extend the successes achieved in treatment. This is done by focusing on:

- the reduction or elimination of risk factors that contribute to substance abuse relapse;
- the constructive handling of episodes of relapse;
- productive involvement of the client in school or work, leisure activities, family and peer networks;
- the development and enhancement of social supports in the community;
- case management functions, such as ongoing assessment, planning, linking, monitoring and advocacy, to ensure the continuity of care after treatment.

FUNCTIONS:

Relapse Prevention and Management consists of helping youth to maintain the progress they have made after the treatment/rehabilitation phase has ended and to deal constructively with relapse to drug and alcohol use if and when this occurs.

Relapse is a reality for the majority of young drug users after treatment. In many cases, incidents of relapse will begin almost immediately after treatment ends.

To ensure that relapse is not viewed as an undoing of all that has been achieved, the possibility of relapse should be discussed during the treatment phase. This involves initial preparation for what can be done to prevent it and how relapse will be dealt with it when and if it occurs.

Relapse management is further developed, implemented, monitored and amended, as necessary, in the continuing care phase.

Social Support Development consists of helping youth to achieve productive community integration through activities that are not compatible with drug use or other problematic behaviors and that involve positive relationships with other people.

The development of social supports is a critical component of treatment, and it is particularly challenging for youth who attend day and residential treatment. Helping to reintegrate the youth into full community life after a structured program requires:

- ongoing supportive counselling;
- monitoring of progress;
- linkage with needed services;
- advocacy.

PLANNING:

Continuing care is a crucial component of the continuum of treatment that must not be overlooked by planners of addiction services. Treatment programs should and usually do provide continuing care themselves, or else develop a collaborative continuing care arrangement with service providers in the youth's home community.

Planners should develop continuing care options that maximize continuity of care and the likelihood that clients will attend. Drop out at the end of treatment and failure to return for ongoing care are common occurrences with youth.

- Continuing care with the treatment setting is likely to be the best choice, at least for clients who live within easy travel distance.

- Continuing care may also be provided by a case manager where this function has been formally integrated into the treatment system.

Attendance at self-help groups, such as AA, CA or NA, can be an important aspect of continuing care. Such groups are a source of social support to some clients, but need to be supplemented by case management. It should not be presumed that self-help groups are appropriate for all youth.

Many young people do not identify themselves as "alcoholic" or an "addict" and consequently do not feel comfortable with these groups. Also, youth are often reluctant to participate in groups dominated by adults.

In short, some structured continuing care component is very important. Twelve-step groups may be a valuable supplement to this process.

Inter-Agency Collaboration may be extremely important in the provision of continuing care.

Residential treatment programs will need to make provision for continuing care in the home community of the client. Wherever possible, this can be arranged through the local assessment and referral centre or other referring agency.

In communities where neither assessment, referral nor outpatient treatment services exist, you will have to make special provision for young clients' continuing care, either on a case-by-case basis or as an inter-agency service agreement.

Some creative options for continuing care provision in communities where there are no addiction-specific services are:

- The referring professional (e.g., school counsellor, physician, probation officer, youth or family worker) may be in an excellent position to provide ongoing continuing care and case management. This person may need regular consultation with the treatment program, and/or "coaching" about the continuing care role and the needs of the client.

- Local family or counselling services may enter into an agreement with the treatment centre to provide continuing care. It will usually be necessary to train a key person in the local agency as part of the agreement.

- Some schools have developed continuing care programs for youth who have attended treatment programs. This is most likely in high schools where a large number of students experience problems with drugs, and staff have developed a relationship with the treatment centre.

- Substance abuse treatment agencies that serve rural areas have designated continuing care workers to travel to clients' own communities.

- In remote areas, another alternative is to offer continuing care by phone contact.

IMPLEMENTATION:

Policies and Procedures: the treatment plan should include decisions about how continuing care will be provided: i.e., who, where and how often.

Continuing care is a very important component of the continuum of care that tends to be overlooked by the client. Therefore, expectations that treatment will be followed by continuing care will need to be discussed during treatment planning.

- The duration of continuing care should be flexible, based on clients' needs. A minimum of six months is generally needed to achieve after-treatment stability; often, clients require up to a year, or even longer.

- The frequency of continuing care contacts should be according to the clients' needs. In the first months after treatment, contact should be frequent -- i.e. weekly following intensive day or residential treatment, and at the same frequency as out-patient contact at the end of treatment. The frequency of contact can be tapered off over time as the client stabilizes. Additional continuing care contact should be available on an "as needed" basis in case the client is faced with a crisis or other problematic circumstance.

- Continuing care can be offered on an individual or group basis. It may be appropriate to deliver continuing care in the same modality as the treatment. Whatever the treatment modality, continuing care delivered in a group context facilitates ongoing peer support after treatment.

- Involvement of the family in the continuing care phase is usually a good idea, especially to ensure relapse management and facilitate integration into family and community after a course of inpatient treatment.

- Youth are often unreliable about keeping scheduled appointments. Therefore, policies and procedures are needed for outreach to clients who fail to stay in regular contact.

Staffing: the staff who are to provide continuing care for youth will need to be carefully selected.

The counsellors who provided either the original treatment or case management (if these are not the same person) will be most knowledgeable about the client's treatment plan and progress, and will already have established a therapeutic relationship with him/her. They will, therefore, be in the best position to achieve a smooth transition between treatment and continuing care for the young client.

CASE EXAMPLE

The Adolescent Residential Program of the Smith Alcohol and Drug Dependency Clinic in Thunder Bay is a short-term residential program for youth ages 14-17 from all over Ontario.

Continuing care for local youth is provided in the Smith Clinic's Options for Youth outpatient program. The three phases of this program consist of:

- Affirmation (3 weeks of daily visits);
- Planning for Success (3 weeks of 3 visits a week);
- Supportive Counselling (3 months of weekly visits).

These phases allow the youth to gradually taper off their involvement in continuing care. Adjustments to this schedule are made according to need.

Family, individual and group modalities are offered in each phase. The primary counsellor of Residential Programs facilitates a smooth transition into aftercare by meeting with the youth and the Options counsellor to discuss the care plan and to orient the youth to the new program and counsellor.

One of the high schools in Thunder Bay is setting up a special support program for youth returning to school after treatment for a substance abuse problem. Referrals from treatment programs are matched with a mentor, a teacher or a peer, who provide support to assist with the youth's integration at school. This school-based program is an integral part of continuing care with the youth, mentor and aftercare counsellor working together to identify the care plans for this phase.

Young people's self-help groups are set up in one of the high schools and at the Smith Clinic. The 12-step model has been adapted to make it more meaningful to adolescents and serves as an adjunct to the continuing care program.

CASE EXAMPLE continued

For youth living outside Thunder Bay, continuing care arrangements are made through the referring agency. Weekly contact is maintained with the agency while the youth is in the residential program, and continuing care service needs and appropriate resources are discussed and planned. To ensure a smooth transition between treatment and continuing care, discharge from the residential program is delayed until the continuing care services are available.

Through fund-raising with the private sector, the Adolescent Residential Program has been able to offer a two-week camping revisit program for youth in aftercare. Eight youth and staff camp at a provincial campground for a program of recreation, life skills, individual and group therapy, focusing on relapse management and the recovery process.

For more information on the Adolescent Residential Program, contact Karen Dahl, 35 North Algoma St., P.O. Box 3251, Thunder Bay, ONT. P7B 5G7. Phone: (807) 343-2421.

RESOURCES:

Youth and Drugs: An Educational Package for Professionals. (1991). The Addiction Research Foundation. Unit 5 has a section on continuing areas of relapse management.

8. CASE MANAGEMENT

8. CASE MANAGEMENT

Case management is the process of assessing, planning, linking, monitoring and advocating to ensure co-ordination and continuity of care.

Case management is a very important function that should be provided throughout all phases of the continuum of care.

The term "case management" is typically used to describe a variety of different activities. In this section, it refers to co-ordination functions, which should be distinguished from a variety of activities performed by "prime therapists," in order to manage the treatment plans. Ideally, the case manager is a practitioner who is in a position to oversee and, when necessary, intervene in the treatment process.

The overall objective of case management is to rationalize and individualize the services delivered to each youth.

SERVICE OBJECTIVES:

- to ensure that adequate assessment and treatment plans are arranged, and that review of the young client's strengths, problems and needs is ongoing;
- to identify and refer youth to needed services, and ensure that co-ordination of care and linkages between care givers are maintained;
- to continuously monitor and evaluate the young client's progress, and provide post-treatment followup and support;
- to advocate on behalf of the young client;
- to activate crisis intervention services when needed.

The case management approach is particularly appropriate for young clients, for the following reasons:

- young clients often have a range of lifestyle or behavioral problems, including alcohol and drug use, which calls for multiple interventions;

- case management can provide continuity in a service system that is fragmented;

- case management allows the young client to work on areas that he/she is ready to change while at the same time making the connection between substance use and other life problems;

- it is often difficult for youth to advocate on their own behalf;
- youth do not have as much autonomy in decision-making as adults;
- youth do not have equal access to resources such as money, information, transportation;
- young clients may not see their alcohol/drug use as a problem, and therefore may be ambivalent about attending traditional programs requiring abstinence as a criterion for admission;
- young clients may not be willing to engage in a program that requires regular attendance;
- youth are very likely to drop out of the treatment process, frequently to return again at a later date;
- the process of resolving a drug problem, like its development, may be a gradual one.

PLANNING:

Whether care is provided by a single administration (e.g., in a multi-functional centre), or as part of an inter-agency collaboration, there should be agreement about a number of issues:

- the scope of case management functions;
- who will undertake them;
- how individual clients will be assigned to a case manager;
- empowerment of the case manager to advocate and secure services for his/her clients.

Inter-Agency Collaboration: case management, in the context of a multi-functional treatment program, requires inter-agency clarification of roles and responsibilities for both on-site care givers and those in other agencies.

Case management can be provided wherever young clients enter the system.

It occurs naturally in a number of settings, without being formally defined as a separate function. Examples include activities undertaken by probation and aftercare officers, school social workers, child welfare workers, etc. as part of their normal workloads.

One option for a multi-functional program is to assign a case manager at the time of initial contact. If the client already has a case manager from another agency, the prime therapist will maintain contact with this person while the youth is in his/her care.

IMPLEMENTATION:

Policies and Procedures must be in place to provide effective case management. They include:

- **Client-Centred Policies** should be developed. It is important to ensure that the case manager does not "take over" from the young client. The object of the case management process is to assist and support the young client in developing the skills needed to make decisions and advocate on his/her own behalf. Nevertheless, case management may involve advocating on behalf of both the youth and his/her family, as well as negotiating between the youth and family members or the youth and care givers.

- **Policies That Deal with Dropout** are crucial to case management. Studies of young drug users in outpatient treatment indicate that attendance tends to be sporadic and of short duration (1-3 sessions after assessment), and there's a high rate of early dropout (about 50%). In the case of early dropout, every effort should be made to discover the reason and to make appropriate adjustments to the treatment plan.

    - Clients who drop out because they have achieved their immediate goals should be followed for continuing and ongoing case management.

    - Clients who drop out because of instability in their lives and/or ongoing drug use should be considered for more intensive and structured treatment.

    - Clients who drop out because they have "changed their minds" about treatment should receive ongoing case management, and be watched for signs that supportive counselling or crisis intervention are needed.

- **Policies and Procedures for Re-entry into the Program** should be in place for youth who wish to continue their treatment.

Staffing must be considered when determining who will take on the role of case management.

Additional staff resources for case management are usually not required, because the assessment counsellor or primary therapist will most likely perform these functions. However, when assigning caseloads, consideration should be given to the fact that these functions are time-consuming.

RESOURCES:

For further information on the issues and steps involved in setting up a case management component, see:

Graham, K., and Timney, C. B., (1990). "Case management in addictions treatment." ***Journal of Substance Abuse Treatment***, Vol. 7, 181-188.

Graham, K., Bois, C., Timney, C. B., (1989). "Defining the coordination and advocacy components of case management in addictions treatment, Part 1." Internal Document #109. Toronto: Addiction Research Foundation.

Lightfoot, L., Rosenbaum, P., Ogurzsoff, S., Laverty, G., Kusiar, S., Barry, K., & Reynolds, W., (1982). "Final report of the Kingston treatment programme development research project." Department of Health and Welfare, Canada.

Willenbring, M., Ridgely, M. S., Stinchfield, R., and Rose, M., (1990). "Application of case management in alcohol and drug dependence: Matching Techniques and Populations". (Submitted to NIAAA).